Nov. 8. 2013 5:20PM SHC BUSINESS OFFICE No. 894 1 RIN 1 11/05/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445369 B. WING 10/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2750 EXECUTIVE PARK PLACE CLEVELAND CARE & REHABILITATION CENTER CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAĞ DEFICIENCY) K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 1) The corridors fire door next to room 302 SS≈E was immediately adjusted by the Doors protecting corridor openings in other than Maintenance Director to latch within the door 14262013 required enclosures of vertical openings, exits, or frame on 10/21/2013. hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core 2) All corridor fire doors were checked by wood, or capable of resisting fire for at least 20 the Maintenance Director to ensure latching 11-269013 minutes. Doors in sprinklered buildings are only within the door frame on 10/21/2013. No required to resist the passage of smoke. There is aberrances were noted. no impediment to the closing of the doors. Doors are provided with a means suitable for keeping 3) The Fire Drill Documentation form was the door closed. Dutch doors meeting 19.3.6.3.6 revised to include an audit of each corridor's åre permitted. 19.3.6.3 fire door to ensure that it latches within the door frame by the Maintenance Director, and 11-26-2013 Roller latches are prohibited by CMS regulations Administrator on 11-7-2013. in all health care facilities. 4) This Fire Drill Documentation audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator weekly for four weeks, and monthly thereafter. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include Director of Nursing. Assistant Director of Nursing, MDS This STANDARD is not met as evidenced by: Coordinators, Staff Development Based on observations, It was determined the Coordinator, Treatment Nurse, Skilled Unit facility failed to maintain the doors protecting the Manager, Administrator, Medical Director. corridors. Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and 11-26-2013 The finding included: Activities Director for further recommendations. Observation during the fire drill on 10/21/13 at 12:29 AM,, revealed the corridor's fire door next to room 302 did not latch within the door frame. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/21/13. MABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (Xe) DATE

Any deficiency statement ending with an asterisk (Naenotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Nov. 8. 2013 5:20PM SHC BUSINESS OFFICE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 8941 P 9 PRINTED: 11/05/2013 FORM APPROVED OMB NO. 0938-0391

CENTE	<u>RS FOR MEDICARI</u>	& MEDICAID SERVICES		<u>`</u>	MB NO	. 0938-0391
STATEMENT AND PLAN (	TÖF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION . 3 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY MPLETED
		445369	B. WING_		40	ingingi
1	PROVIDER OR SUPPLIER AND CARE & REHAE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2750 EXECUTIVE PARK PLACE	1 10/	22/2013
<u> </u>	<u> </u>		<u> </u>	CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	I EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
K 038 SS≂D	Exit access is ama	NFETY CODE STANDARD  Inged so that exits are readily nes in accordance with section	K 034	immediately reset at the key pad and of for adjustment by the Director of Maintenance on 10-21-13; which then the 15 second test and opened properly	hecked passed	11-26 2013
				2) All exit doors were checked by the Director of Maintenance on 10-21-201 aberrances corrected immediately.	3 with	11-26-2013
	Based on testing a determined the fac if he finding include items of the fiftee at the end of the 10 AM revealed it did	s not met as evidenced by: and observation, it was fility failed to maintain the exits. d: n second delayed egress door 10 hall on 10/21/13 at 11:45 not release after fifteen did release upon alarm		<ul> <li>3) An audit tool was developed by the Administrator to audit the exit doors of 2013. Exit doors will be tested for 15 delay bi-weekly by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator.</li> <li>4) This audit will be completed by the Maintenance Director, Assistant Maintenance</li> </ul>	n 11-7- second	11-26-2013
K 051	activation.  This finding was activated in the state of t			Director, and/or Administrator bi-week Aberrances will be corrected immediat These audits will be reviewed quarterly the Quality Assurance committee to in Director of Nursing, Assistant Director	dy, ely. y by clude	
\$S=D	A fire alarm system devices or equipme NFPA 72, National effective warning of Activation of the comanual fire alarm in	with approved components, ent is installed according to Fire Alarm Code, to provide fire in any part of the building. implete fire alarm system is by initiation, automatic detection or	K 051	Development Coordinator, Treatment a Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, S Services, Dietary Manager, Maintenand Director, and Activities Director for fur recommendations.	ocial ce	(1-26-2013
	patient sleeping are that manual pull sta nurse's stations. P path of egress. Ele tests are available.	m operation. Pull stations in eas may be omitted provided ations are within 200 feet of ull stations are located in the ectronic or written records of Areliable second source of Fire alarm systems are	,	K 051 1) The Maintenance Director immediat contacted Century Fire Protection on 1 2013. Century Fire Protection ordered special programing module on 10-22-2	0-21- a	11-26-2013;

Nov. 8. 2013 5:20PM SHC BUSINESS OFFICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 8941 P. 10 PRINTED: 11/05/2013 FORM APPROVED

STATEMENT	OF DEFICIENCIES	CAL PROPERTY OF THE COLUMN					<u>. 0938-0391</u>
AND PLAN C	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. SUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY . COMPLETED	
		445369	B. WING	i		10/	22/2013
NAME OF F	ROVIDER OR SUPPLIER		_	Ş	TREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · ·	22/2010
CLEVE:					750 EXECUTIVE PARK PLACE		
CLEVEL	AND CARE & REHAB	LITATION CENTER					
	1 011111111111				LEVELAND, TN 37312		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 051	maintained in accorrecords of maintena	dance with NFPA 72 and ance are kept readily available. nunciation of the fire alarm	Κ¢	) <b>61</b>	2) All residents have the potential to be affected. The Maintenance Director immediately contacted Century Fire Protection on 10-21-2013. Century Fire Protection replaced the dialer program module on 10-24-2013.	re ming	11-26-3013
,					3) An audit tool was developed by the Administrator to audit the remote annu for showing trouble when the phone lindown on 11-7-2013; which will be con by the Director of Maintenance, Assist Director of Maintenance, and/or Administrator.	nciator les are lpleted	11-26-2013
K 062 SS≕E	Based on testing and determined the facilial alarm.  The finding included Testing on 10/21/13 main Fire Alarm Conturse's station did recommunication line. This finding was acl maintenance direction of the exit conference of the continuously maintenance on the condition and are in determined to the condition and are in determined.	at 12:13 PM revealed the ntrol Panel and panel at the not show a frouble when the was disconnected.  Knowledged by the parand the facility administrator erence on 10/21/13.  FETY CODE STANDARD  sprinkler systems are lined in reliable operating	<b>K</b> 0	162	4) Audit will be completed by the Maintenance Director, Assistant Maint Director, and/or Administrator weekly four weeks and monthly thereafter. Aberrances will be corrected immediat These audits will be reviewed quarterly the Quality Assurance committee to inthe Director of Nursing, Assistant Dire Nursing, MDS Coordinators, Staff Development Coordinator, Treatment I Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, S Services, Dietary Manager, Maintenant Director, and Activities Director for fin recommendations.  K 062  1) The Maintenance Director immediately contacted Century Fire Protection or 10-21-Century Fire Protection ordered the 8 sprink the front entrance canopy on 10-31-20013.	for ely. by clude cter of vurse, ocial co	11-26-2013
	9.7.5		-		The Maintenance Director immediately a all sprinklers on 10-21-2013. No other abert were noted.	uudited rances	11-26-203

No. 8941 P. 11
PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938 0301

K 062 Continued From page 3  This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system.  The finding included:  Observation on 10/21/13 at 10:35 AM, revealed the front entrance canopy had 8 corroded sprinklers.  This finding was vertified by the maintenance supervisor and acknowledged by the administrator during the exit conference on observations are adopted and include no less than the following provisions:  (1) Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible malerial and safe design are provided in all areas where smoking is permitted.	DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	: 11/05/2013 APPROVED
CLEVELAND CARE & REHABILITATION CENTER  CLEVELAND TARS PLANCE CORRECTION  (ACAND REFORM MANY TEMPERCEMENT OF DEPICIENCES TAGE  (ACAND REFORM MANY TEMPERCEMENT OF DEPICE OF TAGE  (ACAND REFORM MANY TEMPERCEMENT OF DEPICE OF TAGE  (ACAND REFORM MANY TEMPERCEMENT OF THE APPROPRIATE DEPICE OF TAGE  (ACAND REFORM MANY TEMPERCEMENT OF THE APPROPRIATE DEPICE OF TAGE  (ACAND REFORM MANY TEMPERCEMENT OF THE APPROPRIATE DEPICE OF TAGE AND THE APPROPRIATE DEPOCRATION OF TAGE OF TAGE OF TAGE AND THE APPROPRIATE DEPOCRATION OF TAGE OF	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION (X3) DAT	'E SURVEY
STREET ADDRESS, CITY, STATE 2 CODE   2750 ENCENTIVE PARK PLASTICE   CLEVELAND, TN 37312			445369	B. WING	i		/22/2013
SUMMARY STATEMENT OF DEFICIENCIES PREFER ID PREFIX EACH DEFICIENCY MAYS BE PRECEDED BY FILL REGULATORY OR LSG IDENTIFYING INFORMATION)  K 082  Continued From page 3  Continued From page 3  This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system.  The finding included:  Observation on 10/21/13 at 10:35 AM, revealed the front entrance canopy had 8 corroded sprinklers.  This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 80/21/13.  K 088  SS-E  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smcking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.			LITATION CENTER	<u>!</u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 750 EXECUTIVE PARK PLACE	22/2013
Continued From page 3  This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system.  The finding included:  The finding included:  Observation on 10/21/13 at 10:35 AM, revealed the front entrance canopy had 8 corroded sprinklers.  This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on a0/21/13.  K 066  NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smcking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	PREFIX	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL	PR∉F	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	This STANDARD is Based on observation to main The finding included Discretion on 10/2 the front entrance of sprinklers.  This finding was very supervisor and acknowled administrator during 10/21/13.  NFPA 101 LIFE SAME Smoking regulations less than the following standing any other hazarea is posted with sor with the internation (2) Smoking by patients are provided permitted.  (3) Ashtrays of nond design are provided permitted.	s not met as evidenced by: ions, it was determined the ntain the sprinkler system.  21/13 at 10:35 AM, revealed anopy had 8 corroded  iffied by the maintenance nowledged by the the exit conference on  FETY CODE STANDARD  is are adopted and include no ing provisions: ibited in any room, ward, or flammable liquids, or oxygen is used or stored cardous location, and such signs that read NO SMOKING anal symbol for no smoking.  ents classified as not bited, except when under  combustible material and safe in all areas where smoking is  with self-closing cover ashtrays can be emptied are			3) Audit tool was developed by the Administrator to audit the sprinklets on 11-7-2013. This audit will be completed by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator.  4) An audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator weekly for four weeks and monthly thereafter. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dictary Manager, Maintenance Director, and Activities Director for further recommendations.  K 066  1) Director of Maintenance ordered metal containers with self-closing cover devices into which ashtrays can be emptied for the staff and residents smoking areas on 10/23/2013 from Direct Supply.  2) There are no other smoking areas.  3) Review of the standard was completed by the Director of Maintenance, and Administrator regarding use of metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas on 10-21-2013. Observation of the metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas on 10-21-2013. Observation of the metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, and/or	11-26-2013 h-26-2013

## DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/05/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT ÖF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445369 B. WING 10/22/2013 -NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2750 EXECUTIVE PARK PLACE CLEVELAND CARE & REHABILITATION CENTER CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 066 Continued From page 4 4) Preventive Maintenance logs regarding the K 066 observation of the metal containers with selfpermitted. 19.7.4 closing cover devices into which ashtrays can be emptied for the smoking areas that were completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing. This STANDARD is not met as evidenced by: Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Based on observations, it was determined the facility failed to provide metal containers with Skilled Unit Manager, Administrator, Medical self-closing cover devices into which ashtrays can Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and be emptled are readily available to all areas 11-26-203 Activities Director for further recommendations, where smoking is permitted. K 130 The findings included: 1) The Director of Maintenance and Assistant Director of Maintenance filled the following with Observation on 10/21/13 at 11:55 AM, revealed 3M Fire Barrier sealant CP 25WB+ a) 300 there were no metal containers with self-closing corridor fire wall next to room 300 four cover devices into which ashtrays can be emptied penetrations, b) 100, 200, 300 and 400 corridor at the staff and residents smoking areas. ceiling fire walls penetrations, c) top and sides of 1-24-2013 the 300 and 400 corridors wall penetrations, d) the service corridor fire wall, low voltage wires not This finding was verified by the maintenance sealed at the wall, e) around conduit through supervisor and acknowledged by the ceiling in electrical closet by the maintenance administrator during the exit conference on office penetrations on 11-11-2013. 10/21/13. K 130 NFPA 101 MISCELLANEOUS K 130 2) Maintenance Director and Assistant SS=F 11-26-2013 Maintenance Director reviewed other areas for OTHER LSC DEFICIENCY NOT ON 2786 penetrations with aberrances corrected by 11-11-2013. 3) Raview of the standard was completed by the

FORM CMS-2587 (02-99) Previous Versions Obsolete

This STANDARD is not met as evidenced by:

roof or floor deck above. Any voids or gaps

foundation or floor below to the underside of the

created by the meeting of the wall and floor below

and the underside of the roof or floor deck above

shall be filled with an approved material with a fire

A fire barrier wall shall extend from the

Event ID: QJLD21

Facility ID: TN0803

immediately.

Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding

Penetrations on 10-21-2013. Observation for

penetrations will be reviewed monthly on the

preventive maintenance log by the Director of

Maintenance, Assistant Director of Maintenance,

and/or Administrator. Aberrances will be corrected

If continuation sheet Page 5 of 8

11-26-2013

No. 8941 P. 13
PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	): 11/05/2013 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DA			. 0938-0391 TE SURVEY MPLETED
<del></del>		445369	B. WING			/22/2013
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>
CLEVELA	ND CARE & REHAB	LITATION CENTER			750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312	ĺ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
K 147 SS=D	wall. National Fire 1 221, 3.2 Penetrations and m barriers such as pip cables, wires, air du ducts, and similar b pass through fire ba material that is capa resistance of the fire Based on observati facility failed to com required.  The findings include benetrations in the five b. 100, 200, 330 ar walls. c. Top and sides of walls were not sealed d. Service corridor sealed at the wall. e. Around conduit the closet by maintenar finis finding was ver supervisor and ackr administrator during in/21/13. NFPA 101 LIFE SAI	least equal to that of the fire Protection Association (NPPA) iscellaneous openings in fire les, conduits, bus ducts, icts, pneumatic tubes and uilding service equipment that arriers shall be filled with a able of maintaining the fire is barrier.  Ons, if was determined the ply with the life safety code as add:  21/13 at 10:58 AM, revealed following areas:  wall next to room 300, 4 wall.  Ind 400 corridor ceiling fire the 300 and 400 corridors and at the fire walls. Fire wall, low voltage wires not arough ceiling in electrical ace office.	K1	47	4) Preventive Maintenance logs regarding the observation of penetrations completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.  K 0147  1) The Maintenance Director and Assistant Maintenance Director 1) moved the oxygen concentrator plugs from the power strips in room 405 and 302 to the emergency outlet, 2) removed the power strip form the Chaplains office 3) removed the power strip from the therapy room on 10-21-2013.  2) Audit of care and non-care areas was completed by the Maintenance Director to ensure no other power strips were plugged into multi-plug adapters, and medical equipment was plugged into the emergency outlet. This audit was completed on 10-23-2013.  3) Review of the standard was completed by the Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding maintaining the electrical wiring, and equipment on 10-21-2013. Staff Development Coordinator, Administrator, and Director of Maintenance provided education to the facility staff regarding the use of power strips and to ensure medical equipment is plugged into the emergency outlets by 11-15-2013. Observation for use of power strips and medical equipment plugged into the emergency outlets will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, Assistant Director of Maintenance, Assistant Director of Maintenance, and/or	
	(02-99) Previous Versions				Administrator. Aberrances will be corrected immediately.	
	o tograpo el exione vetalons i	Obsolete Event ID: QULD21		E a a	Allty ID: TN0803 If continuation she	. <b></b>

No. 8941 P. 14
PRINTED: 11/05/2013
FORM APPROVED

ID HUMAN SERVICES				RINTED: FORM	. 11/05/2013 APPROVED
	VSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATI	0938-0391 E SURVEY PLETED
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ST BE PRECEDED BY FLIL			(EACH CORRECTIVE ACTION SHOULD )	BE	(X5) COMPLETION DATE
ot met as evidenced by: s, it was determined the n the electrical wiring and 1/13 at 11:04 AM revealed olugged into power strips in 302. 1/13 at 11:15 AM revealed ips in the chaplain's office. 1/13 at 11:36 AM revealed into a multi-plug adapter in e start of the 200 hall. eknowledged by the and the facility administrator face on 10/21/13.	К1	47,	4) Preventive Maintenance logs regarding the of power strips, and medical equipment pluginto the emergency outlets completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator monthly will reviewed quarterly by the Quality Assurance committee to include the Director of Nursing Assistant Director of Nursing, MDS Coording Staff Development Coordinator, Treatment Skilled Unit Manager, Administrator, Medic Director, Nurse Practitioner, Social Services Director, Nurse Practitioner, Social Services Director, Manager, Maintenance Director, an Activities Director for further recommendated that the Director of Maintenance moved Alc Based Hand Rub dispensers located over lig switches in the therapy room, and in the central bath in the 300 hall on 10-21-2013.	gged ce be g nators, Nurse, cal s, d ions.	11-262013
NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:		111	encure they were not justalled over or adjace	ent to	11-510-3013
st 6 feet wide lual fluid dispenser ers (2 liters in suites of a minimum spacing of 4 ft lons are used in a single utside a storage cabinet.			Director of Maintenance, Assistant Director Maintenance, and Administrator regarding value Alcohol Based Hand Rub Dispensers are inson 10-21-2013. Observation for placement Alcohol Based Hand Rub Dispensers places will be reviewed monthly on the preventive maintenance log by the Director of Mainten Assistant Director of Maintenance, and/or	of where stalled of nent ance,	11-26-2013
	ATION CENTER  TENT OF DEFICIENCIES SIT BE PRECEDED BY FULL DENTIFYING INFORMATION)  6 al Electrical Code, 9.1.2  of met as evidenced by: s, it was determined the in the electrical wiring and  1/13 at 11:04 AM revealed plugged into power strips in 302.  1/13 at 11:15 AM revealed ips in the chaplain's office. 1/13 at 11:36 AM revealed into a multi-plug adapter in the start of the 200 hall.  Eknowledged by the and the facility administrator ince on 10/21/13. TY CODE STANDARD  Hand Rub (ABHR) d in a corridor: st 6 feet wide fuel fluid dispenser ters (2 liters in suites of a minimum spacing of 4 ft  Ions are used in a single utside a storage cabinet, istalled over or adjacent to	MEDICAID SERVICES ) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445369  E. WING  ATION CENTER  JENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  A BUILD  ATION CENTER  JENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  A BUILD  A BUI	MEDICAID SERVICES ) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:  445369  EATION CENTER  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  IN TAG  A BUILDING  ST  ATION CENTER  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  ID PREFIX TAG  K 147  A BUILDING  ID PREFIX TAG  ID PREFIX TAG  K 147  A BUILDING  ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG  K 147  A BUILDING  ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG  K 147  A BUILDING  ID PREFIX TAG  ID PREFIX TA	MEDICAID SERVICES ) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER:  446369  A BUILDING 01 - MAIN BUILDING 01  A BUILDING 01  A BUILDING 01  PROVIDERS PLAN 0F CORRECTION  A CACH CARRE PLACE  CLEVELAND, TN 37312  PROVIDERS PLAN 0F CORRECTION  A CACH CARRE PLACE  CLEVELAND, TN 37312  A CACH CARRE PLACE  CLEVELAND, TN 37312  A PROVIDERS PLAN 0F CORRECTION  A BUILDING 01  A PROVIDERS PLAN 0F CORRECTION  A CACH CARRE PLACE  CLEVELAND, TN 37312  A CACH CARRE PLACE  CLEVELAND, TN 37312  A PROVIDERS PLAN 0F CORRECTION  A PROVIDERS PLAN 0F CORECTION  A CACH CARRE PLACE  CLEVELAND, TN 37312  A PROVIDERS PLAN 0F CORRECTION  A PROVIDERS PLAN 0F CORECTION  A PROVIDERS PLAN 0F CACH  A CACH CARRE PLACE  CLEVELAND, TN 37312  A PROVIDERS PLAN 0F CORECTION  A PROVI	ID HUMAN SERVICES  MEDICAID SERVICES  MEDICAID SERVICES  MEDICAID SERVICES  MEDICAID SERVICES  MEDICAID SERVICES  MEDICAID SERVICES  DEPORTED TO BE COMMUNITIES CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 - COMMUNITIES CODE  2750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312  ENT OF DEFICIENCIES SIT BE PRECEDED 8Y FULL DENTIFYING INFORMATION)  MEDICAID SERVICES  STREET ADDRESS, CITY, STATE, ZIP CODE CLEVELAND, TN 37312  ENT OF DEFICIENCIES SIT BE PROCEDED 8Y FULL DENTIFYING INFORMATION)  MEDICAID SERVICES  ASSERTERENCED TO THE APPROPRIATE DEFICIENCY  AND THE ASSENCE CONTRACT OF THE APPROPRIATE DEFICIENCY  AND THE ASSENCE CONTRACT OF THE APPROPRIATE DEFICIENCY  A Preventive Maintenance logs regarding the use of power strips, and medical equipment plugged into the emergency outlets completed by the Maintenance Director, and/or Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MIDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, MIDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, and Activities Director for further recommendations.  MEDICAL PROCESTER AND CODE  K 1477  A) Preventive Maintenance logs of Nursing, MIDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator monthly will be reviewed monthly on the Director of Maintenance moved Alcohol Based Hand Rub dispensers to ensure they were not installed over or adjacent to an ignition source on 10-25-2013. Aberrances were convected immediately.  2) The Director of Maintenance completed by the Director of Maintenance, and Administrator regarding where convected immediately.  3) Review of the standard was completed by the Director of Maintenance, and Administrator regarding where convected immediately.  3)

Nov. 8. 2013 5:22PM SHC BUSINESS OFFICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 8941 P. 15 PRINTED: 11/05/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) I AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	445369	B. WING			10/2	22/2013
NAME OF PROVIDER OR SUPPLIER  CLEVELAND CARE & REHABILITATION CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 750 EXECUTIVE PARK PLACE LEVELAND, TN 37312		
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
This STANDARD is not Based on observations, facility failed to ensure A (ABHR) dispensers were adjacent to an ignition of The finding included:  Observation on 10/21/13 dispensers located over therapy room and in the hall.	the building is fully CFR 403.744, 418.100, 483.623, 485.623  met as evidenced by: It was determined the Ilcohol Based Hand Rub e not installed over or ource.  B at 11:12 revealed ABHR light switches in the central bath in the 300  Medged by the Ind the facility administrator	К;	211	· · · · · · · · · · · · · · · · · · ·	ted by mance I be e instors, Nurse, cal	11-26-203